

[Physician Name/Medical Clinic Name]
[Address]
[City, State, Zip Code]
[Phone Number]

[Date]

To: [Employer Name/Company Name]
Attn: [Manager or HR Department Name]
[Company Address]

RE: RETURN TO WORK AUTHORIZATION

Patient Name: [Patient Name]
Date of Birth: [DOB]

Dear [Recipient Name],

This letter is to certify that [Patient Name] has been under my medical care since [Start Date of Absence].

I have evaluated the patient and have determined that they are cleared to return to work effective **[Return Date]**.

The patient's return status is as follows (check one):

Full Duty: The patient may return to work with no restrictions and can perform all previous job duties.

Modified Duty: The patient may return to work with the following restrictions until [Date]:
[List specific restrictions, e.g., no lifting over 10lbs, limited standing, etc.]

If you have any questions or require further clarification regarding these medical instructions, please contact my office directly.

Sincerely,

[Signature of Healthcare Provider]

[Printed Name of Healthcare Provider]
[Medical License Number]